Dept. of Labor and Industries Crime Victims Compensation Program PO Box 44520 Olympia WA 98504-4520

# Program STATEMENT FOR PHARMACY SERVICES

							Instructions for completing form on the reverse side.			
O NOT PRITE IN								nt's soc. sec. no. (for i.d. only)	Claim no.	
ACE							Claima	nt's name (last, first, middle) print or type		
Pharmacy na	ame & ac	ldress		CVC	C Provid	er no. / NPI	Claima	nt's mailing address		
		Federal Tax ID				City		State ZIP		
							Pharm	acy billing date (mm/dd/yyyy)		
	-	uest to reimb vate insuranc			t? [	YES YES	NO NO			
Prescription (F	RX) In	formation	P	rint Or	Гуре А	All Informati	on			
OX Code (ICD-9)	S/B	Date of injury	Date Rx writte	en I	Prescrib	oing Provider's	name			
Prescription #	YES 1						NO			
National Drug Code	•		Drug name					DUR codes		
Remarks					CNFLT: INTRV:  Prescription clarification code (Refill-to-soon)	OUTCM: Total Prescription Cost \$				
OX Code (ICD-9)	S/B	Date of injury	Date Rx written Prescribing Provider's name							
rescription # Date Rx filled			Days supply Quantity (units) Refill			Refill YES	NO	Dispensed as written product selection code (DAW) (0, 1 or 6)		
lational Drug Code	Drug name				_	DUR codes				
						CNFLT: INTRV:	OUTCM:			
Remarks						Prescription clarification code (Refill-to-soon)	Total Prescription Cost \$			
OX Code (ICD-9)	S/B	Date of injury	Date Rx written Prescribing Provider		oing Provider's	name				
escription #		Date Rx filled	Days supply	Quantity (units)		Refill YES	NO	Dispensed as written product selection code (DAW) (0, 1 or 6)		
lational Drug Code	;	Drug name					DUR codes			
Lemarks						CNFLT: INTRV: Prescription clarification code (Refill-to-soon)	OUTCM: Total Prescription Cost \$			
Reimburse the	e claii	mant: Pharma	cist's signa	ture is	reaui	ired.				
		has paid for the								
Phar	macis	t's Signature X								

When you submit this bill, you are certifying that the prescription information is correct.

CVC must receive this statement within 12 months of the date of service, claim allowance or primary insurance payment decision.

\* If primary insurance has made payment, bill only the total that is patient responsibility.



## **Instructions for completing Statement for Pharmacy Services form**

## **Types of Insurance**

#### CRIME VICTIMS

Claim numbers are six digits beginning with a "V", or five digits proceeded by a "VA, VB, VC, VH, VJ, VK or VL." Send bills for Crime Victims claims to:

Department of Labor and Industries Crime Victims Compensation PO Box 44520 Olympia WA 98504-4520

#### STATE FUND INDUSTRIAL INSURANCE

Claim numbers are six digits, beginning with a "B, C, F, G, H, J, K, L, M, N, P, X, Y or double alpha followed by 5 digits."

Send bills for Industrial Insurance claims to:

Department of Labor and Industries PO Box 44269 Olympia WA 98504-4269

#### **SELF-INSURANCE**

Claim numbers are six digits beginning with an "S, T or W." Department of Energy claims are now Self-Insured. Claim numbers are seven digits beginning with "7, 8 or 9." Send bills to the employer or their service company.

### Pharmacy address changes

**PHARMACY NAME AND ADDRESS:** If any of this information changes, call 1-800-762-3716 immediately. (Simply indicating a new address on the bill will not change CVC's record of address for the provider.)

## Pharmacy/Prescription Information

**CVC PROVIDER NUMBER / NPI:** The specific Provider number or NPI issued to the pharmacy.

**FEDERAL TAX ID #:** IRS (Internal Revenue Service) Federal tax identification number.

REIMBURSE CLAIMANT: Place "X" in applicable box.

**S/B (SIDE OF BODY):** Designate "L" (left), "R" (right) side of body or "B" (bilateral), to indicate location of injury.

**DATE OF INJURY:** This is important and must be included. One claimant may have several claims, so it is vital the proper claim be identified and charged for services provided.

**QUANTITY**: The total units of medication prescribed. Use the (NCPDP) billing unit standard format, e.g., "each", "ml" or "gm".

## DISPENSED AS WRITTEN PRODUCT SELECTION CODE:

Code indicating whether or not the prescriber's instructions regarding generic substitution were followed.

#### Valid values are:

- 0 = No product selection mandated;
- 1 = Substitution not allowed by prescriber;
- 6 = Override for emergency supply This value is used only by in-state pharmacies when dispensing an emergency supply of a non-preferred drug prescribed by a non-endorsing practitioner.

**NATIONAL DRUG CODE:** National drug identification code. This code must be entered in a 5-4-2 format: e.g., if the NDC format listed in your pricing book is 0005-3250-23, enter 00005 3250 23. If the NDC format is 50419 127 12 enter 50419 0127 12.

**DUR CODES:** Enter the appropriate conflict, intervention and outcome code.

**PRESCRIPTION CLARIFICATION CODE:** Enter the appropriate value for a refill-too-soon.

**TOTAL PRESCRIPTION COSTS**: Total charge for the filled prescription. (Drug cost + professional fee + applicable tax - primary insurance write off - primary insurance payment).

**REIMBURSE THE CLAIMANT**: Signature of pharmacist who supplied the prescription is required.